Charlotte Tilson, Psy.D.
Psychologist

Acknowledgment of Notifications & Consent
Children & Adolescents

Today's Date:

Child's Name:

I acknowledge receipt of Dr. Tilson's Office Policies and Notice of Privacy Practices. I have read, understand and agree to comply with these policies. I know that these documents are available to me on Dr. Tilson's website, and that I may request a hard copy at any time if I am unable to access them.

I understand that Charlotte Tilson, Psy.D. is a licensed psychologist (PSY 25357) in the state of California.

I consent for my child to participate in this intake evaluation, therapy, and/or consultation. I understand that I may withdraw him/her from treatment or consultation at any time.

I/we will schedule and participate in parent sessions as necessary and appropriate. I/we understand that the purpose of these sessions is to discuss progress, to develop a shared understanding and coordinate efforts that will support growth and development.

In signing this form, I attest that I am the legal guardian or parent of my child and I have the right to grant this permission. If I do not have the right to grant this permission and/or if I share legal custody of this child with another person I will note that below.

- ☐ I give my permission and I attest that I have full legal right to do so.
- ☐ I share legal custody with my child's other parent. Contact him/her at:

  ____

- ☐ I do not have the right to grant this permission. Contact the person named here:

  ____

____
Signature

____
Printed Name

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